FAQs about the AccessTN Company Assessment

(Please note that the response to Illustration #2 of FAQ #23 has changed.)

1) What is AccessTN?

AccessTN is a nonprofit state entity which offers health coverage of last resort to those who cannot get other insurance because of their health status. It is one of 34 State High-Risk Pools in the country that perform this function.

AccessTN is part of the **Cover Tennessee** family of programs for uninsured Tennesseans. It is the only Cover Tennessee program that utilizes annual assessments for a portion of its funding.

2) Is Cover Tennessee a newer version of TennCare?

No. TennCare is a medical assistance entitlement program regulated by federal Medicaid guidelines. In contrast, AccessTN is insurance. The Cover Tennessee programs have been built specifically to help the Tennesseans who do **not** qualify for TennCare and have been going without health insurance, and in many cases, without health care.

3) What is the connection between AccessTN and the old TCHIP insurance?

None. Tennessee Comprehensive Health Insurance Pool (TCHIP) was Tennessee's state high risk pool until 1994, when TCHIP's approximately 4,500 members were allowed to transition into TennCare. AccessTN is again Tennessee's high risk pool, but AccessTN is a new nonprofit state entity and is structured and financed differently than TCHIP.

4) Where is the money coming from to pay for AccessTN?

Funding will come from a variety of sources, including:

- Premiums paid by individuals;
- Premium assistance paid by the State;
- Coinsurance and other cost-share by members;
- State Funds for part of operating costs and reserves;
- Federal seed grant to start the program; and
- Assessment on the insurance industry for part of operating costs and reserves.

5) What is the total cost of AccessTN?

The total cost will depend upon the cost of medical claims of our members. The State has funded a total of $97.8 million for AccessTN over three years. The industry assessment will provide additional funding as necessary, up to the amount of the State appropriations for AccessTN.

6) How many members will AccessTN have?

A thirteen member Board of Directors (Board), representing the public and various parts of the health care and insurance businesses, governs the AccessTN program. The Board is chaired by the Commissioner of Finance and Administration (F&A). The Board limits AccessTN enrollment to the number of members that AccessTN has the financial capacity to insure.

The Board has set an initial enrollment capacity of 6,000 members. As of May 2008, AccessTN had approximately 3,500 members. The Board will periodically review this enrollment capacity, based on

member medical claims and program expenses relative to total funding available from policy premiums, assessments, State appropriations, and any federal grant funds.

7) What is the authority for AccessTN to conduct an assessment?

T.C.A. § 56-7-2911(a) says that the deficit incurred by the pool shall be funded through state appropriations and an assessment on insurers, insurance arrangements and third party administrators. The Board is authorized to determine the amount and allocation of any assessments and advance interim assessments on insurers, insurance arrangements and third party administrators, subject to approval by the Commissioner of Finance and Administration (F&A). The Commissioner shall have the authority to assess insurers, insurance arrangements, and third party administrators, and to make advance interim assessments as may be reasonable and necessary for the pool's organizational and interim operating expenses.

8) Who handles the assessment?

AccessTN staff, within the F&A Benefits Administration Division, will administer the assessment as authorized by the Board and the Commissioner of Finance and Administration. The Tennessee Department of Commerce and Insurance (TDCI) will review whether an assessment will create a hazardous operational or financial condition for the insurer.

9) What companies can be assessed for AccessTN?

Any entity providing or paying for Health Coverage for Tennessee Covered Lives will be assessed. A insurer, health plan, re-insurer, or third party administrator can be assessed for AccessTN. Health Coverage is intended to include all kinds of health benefits plans. Health Coverage can be either fully insured, self-insured, or a combination of coverage.

10) What counts as "Health Coverage"?

"Health coverage" has a specific meaning for purposes of the AccessTN assessment. "Health coverage" is any type of individual or group health benefit plan or other health coverage. It is **not** just health coverage by an Insurer. It also means any hospital and medical expense incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes health care services, whether by insurance or otherwise. Note: AccessTN refers to "health insurance coverage" as "Health Coverage" to reduce confusion with health insurers regulated by the State of Tennessee.

11) What is a "Covered Life" for purposes of the AccessTN assessment?

A "covered life" is a Tennessee resident in a health benefit plan which counts as Health Coverage, even if the coverage was issued in another state. This includes employees on employer coverage, individual policyholders, subscribers, members, or association group (non-employee) certificate holders. It also counts all dependents in these health benefit plans. For purposes of assessment, a Covered Life will be counted as of December 31st of the prior year, even if that individual is no longer covered by the same health benefit plan when the assessment is made. The intent of the assessment is to make sure that the same individual is only counted once for a particular Health Coverage product.

12) What types of insurance are not deemed Health Coverage?

Generally, insurance for which health benefits are only incidental or supplemental to other types of coverage are excluded as Health Insurance Coverage by the statute. This includes Accident Only, Auto Policy Medical Payment/PIP or Auto Policy Optional Medical With/Without Fault, Credit Only, Dental/Vision Only, Disability Only, General Liability Only or Medical Supplement to Liability Insurance, or Worker's Compensation Coverage.

13) Are there any kinds of Health Coverage excluded from the AccessTN assessment?

Yes, Medicaid (TennCare), State Children's Health Insurance (CoverKids), CHAMPUS, TRICARE, Medicare, including Part D, Medicare Supplement, and Medicare Advantage Plans, are excluded. No TPA, health plan, or fiscal intermediary providing those benefits would be assessed for its Covered Lives in those lines of business.

Hospital and other fixed Indemnity policies, Cancer or other Specified Disease-Only policies are **not** included in the net count for purpose of the AccessTN assessment.

Lives covered by these types of Health Coverage products are reported on the 2007 Health Benefit Plan Reporting Form, but will **not** be included in the gross or net count of Covered Lives for purposes of the AccessTN assessment.

14) What insurance products are exempt from assessment for AccessTN?

Health Coverage does **NOT** include the following insurance product lines:

Accident Only, Auto Policy Medical Payment/PIP or Auto Policy Optional Medical With/Without Fault, Credit Only, Dental/Vision Only, Disability Only, General Liability Only or Medical Supplement to Liability Insurance, or Worker's Compensation Coverage.

15) What about limited benefit plans?

Only specified limited benefit types are excluded from the assessment. The excluded plans are cancer-only or other single disease only coverage, dental only, or vision only. However, "mini-med" health plans or other limited health plans ARE Health Coverage for purposes of assessment, and they will be subject to the AccessTN assessment.

16) What is the timing for the assessment to be conducted during 2008?

a) Data Call Issued June 16, 2008

b) Company Response Due July 16, 2008

c) Provisional Assessment for Company Review Sent September 15, 2008

d) Notice of Assessment Sent October 31, 2008

e) Assessment Payment Due December 31, 2008

17) What does the term "Reporting Entity" mean as used in the 2007 Covered Lives Worksheet for the Health Benefit Reporting Form?

Reporting Entities is a term we use in these materials for the companies who have a duty under the Access Tennessee Act to report their Covered Lives in Tennessee for the purpose of assessment. Reporting Entities include companies offering Health Coverage to Tennesseans as an Insurance Arrangement, a Third Party Administrator, an Insurer (including Insurers, Re-insurers, Excess and Stop-loss Carriers) or a combination of Coverage. Companies can be Reporting Entities whether or not they are based or licensed in Tennessee and whether or not the Health Coverage that they provide is contracted for in Tennessee or another State.

18) What counts as an "Insurer" for purposes of assessment?

"Insurer" includes, but is **not** limited to, an insurance company, a health maintenance organization, a preferred provider organization, a hospital and medical service corporation, a surplus lines insurer, an insurer providing stop-loss or excess loss insurance to a group health plan, a reinsurer reinsuring health insurance in this state, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

19) What counts as an "Insurance Arrangement"?

For purposes of assessment, "Insurance Arrangement" means any plan, program, contract or other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a trust or third party administration, health care services or benefits other than through an insurer. Insurance Arrangement shall include any plan described in T.C.A. § 56-2-121(a) as well as Farm Bureau coverage, Multiple Employer Welfare Arrangements (MEWAs), and self-insured Health Benefit Plans for single Employers and other self-funded entities.

20) What is a "Third Party Administrator"?

For purposes of the assessment, a "Third Party Administrator" (TPA) means any entity that, on behalf of an insurer or insurance arrangement, provides Health Coverage to individuals in Tennessee,

receives or collects charges, contributions or premiums for, or adjudicates, processes or settles claims in connection with, any type of health benefit provided in or as an alternative to health insurance coverage.

21) What happens if there are multiple companies involved in providing a health benefit plan?

The 2007 Covered Lives Worksheet included with the 2007 Health Benefit Plan Reporting Form establishes priority among the different entities such that only one entity will pay for each covered life for a health benefit plan.

22) What is the priority of Reporting Entities for purposes of assessment?

The Access Tennessee Act establishes the following priority, in instances when multiple entities are providing the health benefits plan for the same individual:

(1) Insurer, in order of priority:

(a) Primary insurers;

(b) Primary re-insurers; and

(c) Re-insurers, stop-loss, or excess carriers.

(2) If no Insurer, the Third Party Administrator (TPA).

(3) If no Insurer or TPA, the Insurance Arrangement (self-insured MEWA or single employers, directly or by trust).

The higher-ranked entity pays the assessment and the lower ranked entity will report the covered life but then subtract the covered life from its net count for the AccessTN assessment.

For example, consider a self-insured plan (Insurance Arrangement) that is administered by a TPA but also has stop-loss coverage with a different company for those individuals whose medical claims exceed a certain claims level. In this case, the stop-loss carrier would be primary and will include the Covered Lives of that group in its net count of Covered Lives subject to assessment. The TPA would list the lives on its 2007 Covered Lives Worksheet, but would subtract those lives covered by the stop-loss carrier for the box reflecting the TPA's net assessable lives. Please refer to examples for additional information and clarifications.

23) Can you give some examples of how AccessTN will determine who will pay for the covered life when there are multiple entities involved in the coverage?

Yes, three illustrations that follow show how the 2007 Covered Lives Worksheet would treat various entities. The columns of the table provide examples of how the various Reporting Entities would report their lives according to Lines 1-5 and Box A.

Illustration 1: Fully-insured Single Group

Company E is an Employer providing fully-insured group health benefits for 5000 employees through Insurance Company I. T is a Third Party Administrator who administers enrollment and pays claims for I. R is a Re-insurer licensed in Tennessee who will reimburse Company I for covered claims of any of E's employees above and attachment point of $50,000.

2007 Covered Lives Worksheet Section in Calculation for Box A	Worksheet Calculation	Ex. #1 Company E	Ex. #2 Company I	Ex. #3 Company T	Ex. #4 Company R
Reporting Entity Type		N/A	Insurer (First payer)	Third Party Administrator	Insurer (Reinsurer)
Line 1 – Excluded lines Covered Lives	Total Covered Lives in excluded types of Health Coverage	0	0	0	0
Line 2 – Assessable Covered Lives	Total Covered Lives in assessable types	0	5,000	5,000	5,000

	of Health Coverage				
Line 3 – Insurance Arrangement Lives counted by another Reporting Entity	Subtract TPA or Insurer Covered Lives from Line 2	0	0	0	0
Line 4 – TPA Lives counted by another Reporting Entity	Subtract Insurer Covered Lives from Line 2	0	0	5,000	0
Line 5- Reinsurer Lives Counted by Primary Insurer	Subtract Primary Insurer Covered Lives from Line 2	0	0	0	5,000
Box A- Net Covered Lives Subject to Assessment for Reporting Entity	Remainder after subtracting Lines 3,4,5 from Line 2	0	5,000	0	0

Illustration 2: Self-insured Single Group

(Note: This illustration for FAQ #23 has changed as of 6/18/08. The answer is the same but information on Lines 3, 4, and 5 are corrected.)

Assume that G is a trust providing self-insured group health benefits for 6,000 employees of an affiliated Company E. Company T is a Third Party Administrator who administers enrollment and pays claims for E. R is a Re-insurer licensed in Tennessee who will reimburse E for covered claims of any of E's employees above and attachment point of $50,000.

See table below illustrating the assessment calculation for each Reporting Entity. Each Column indicates how that Reporting Entity would complete its 2007 Covered Lives Worksheet.

2007 Covered Lives Worksheet Section in Calculation for Box A	Worksheet Calculation	Ex. #5 Company E	Ex. #6 Company G	Ex. #7 Company T	Ex. #8 Company R
Reporting Entity Type		N/A	Insurer (First payer)	Third Party Administrator	Insurer (Reinsurer)
Line 1 – Excluded lines Covered Lives	Total Covered Lives in excluded types of Health Coverage	0	0	0	0
Line 2 – Assessable Covered Lives	Total Covered Lives in assessable types of Health Coverage	0	6,000	6,000	6,000
Line 3 – Insurance Arrangement Lives counted by another Reporting Entity	Subtract TPA or Insurer Covered Lives from Line 2	0	6,000	0	0
Line 4 – TPA Lives counted by another Reporting Entity	Subtract Insurer Covered Lives from Line 2	0	0	6,000	0
Line 5- Reinsurer Lives Counted by Primary Insurer	Subtract Primary Insurer Covered Lives from Line 2	0	0	0	0
Box A- Net Covered Lives Subject to Assessment for Reporting Entity	Remainder after subtracting Lines 3,4,5 from Line 2	0	0	0	6,000

Illustration 3: Companies with multiple product lines and types of business

Company I provides insurance, both individual and group, and TPA services in Tennessee.

As of 12/31/2007, Company I has the 50,000 Fully-insured employer group Covered Lives, 12,000 Medicare Advantage lives, 10,000 Fully-insured Individual lives; 5,000 Fully insured indemnity. Company I has 40,000 lives for which it performs services as a Third Party Administrator. Those TPA Covered Lives are described below.

Insurance Arrangement A is an association trust which offers coverage to 10,000 association members, with Company I as third party administrator. Company I also provides third party administrator services for 30,000 members in self-insured employer groups, with all of these lives 40,000 re-insured by Reinsurer R, with an attachment point of $50,000.

See table below illustrating the assessment calculation for each Reporting Entity. Each Column indicates how that Reporting Entity would complete its 2007 Covered Lives Worksheet.

2007 Covered Lives Worksheet Section in Calculation for Box A	Worksheet Calculation	Ex. #9 Company A	Ex. #10 Company I	Ex. #11 Company R
Reporting Entity Type		N/A	Insurer (First payer)	Insurer (Reinsurer)
Line 1 – Excluded lines Covered Lives	Total Covered Lives in excluded types of Health Coverage	0	17,000 12,000 5,000 17,000	0
Line 2 – Assessable Covered Lives of this Reporting Entity	Total Covered Lives in assessable types of Health Coverage	10,000	90,000 10,000 30,000 50,000 90,000	40,000 10,000 30,000 40,000
Line 3 – Insurance Arrangement Lives counted by another Reporting Entity	Subtract TPA or Insurer Covered Lives from Line 2	10,000	0	0
Line 4 – Third Party Administrator (TPA) Lives counted by another Reporting Entity	Subtract Insurer Covered Lives from Line 2	0	40,000 10,000 30,000 40,000	0
Line 5- Reinsurer Lives Counted by Primary Insurer	Subtract Primary Insurer Covered Lives from Line 2	0	0	0
Box A- Net Covered Lives Subject to Assessment for Reporting Entity	Remainder after subtracting Lines 3,4,5 from Line 2	0	50,000	40,000

In this illustration, Insurance Arrangement A, Insurer I, and Re-insurer R all provide or pay for the same 10,000 Covered Lives in their respective capacities. However, because A is the lowest priority Reporting Entity, it may subtract on Line 3 the 10,000 lives from it counted on Line 2 of the 2007 Covered Lives Worksheet. Therefore Insurance Arrangement A would have no assessment to pay for this year. The priority for those 10,000 lives between I and R is illustrated below.

Insurance Company I and Reinsurer Company R each provide or pay for health care benefits for the same 40,000 lives, in their respective capacities, and would report that on Line 2 of the 2007 Covered Lives Worksheet. However, the statute assigns the Reinsurer priority for the purposes of assessment. (See FAQ answer number 18 above.)

Therefore, Company I, may subtract those 40,000 lives from its total on Line 4 to report its net total Covered Lives in Box A of the 2007 Covered Lives Worksheet. Company R, as reinsurer, must count those 40,000 Covered Lives in Box A.

Note: If Company I were the primary insurer for these 40,000 Covered Lives, rather contracted as Third Party Administrator, the result would be different.

24) How is the amount of the assessment determined?

After the AccessTN Board determines the AccessTN program's operating deficit for the prior fiscal year (July – June) and the amount of funding needed to pay for the program operations for the next fiscal year (if any), the Board will determine the aggregate assessment amount. The aggregate assessment amount will be numerator of the assessment for the current year. The total number of Tennessee Covered Lives from all reporting entities will become the denominator. The resulting number is the assessment per covered life.

For example, if the operating deficit for FY2007 was $1,000,000, and the Board determined that the anticipated operating deficit for FY2008 would be $2,000,000, the combined aggregate assessment amount would be $3,000,000.

And if the Assessment data call determined the aggregate number of Tennessee Covered Lives to be 3,000,000 lives, the assessment per covered live would be $1.00 per covered life reported by each Reporting Entity.

25) How much does each Reporting Entity have to pay?

Each Reporting Entity would pay a total assessment based upon its net number of covered Tennessee lives (Box A of the 2007 Covered Lives Worksheet) multiplied by the determined assessment per covered life. For example, if Company B reported 30,000 lives in Box A of its 2007 Covered Lives Worksheet, its total assessment (using the $1 assessment per covered life from above) would be $30,000.

26) Is there a limit on how much AccessTN may assess Reporting Entities?

Yes. AccessTN cannot assess insurers and health benefit plans for an aggregate assessment amount greater amount than the aggregate amount of State appropriations for AccessTN.

27) Are there exceptions that allow a company to defer its assessment in a given year?

Reporting Entities will be required to pay their allocated portion of the assessment for all its Covered Lives in included types of Health Coverage. The only exception is when TDCI determines that the assessment for a specific insurer, insurance arrangement, or third party administrator will create a hazardous operational or financial condition for that Reporting Entity.

28) What is an advance interim assessment?

The assessment will always have two parts – the assessment to pay for the pool's deficit for the prior fiscal year and the advance interim assessment. The latter portion is the amount the Board has determined to be necessary to pay for the pool's projected deficit for the next fiscal year.

29) How does the advance interim assessment work?

Each fall, the Board will review the pool's financial results for the prior fiscal year and the actuarial estimate of medical claims for the next fiscal year. The Board will set premiums and enrollment capacity, and will review the state funding available for AccessTN operations. They will then set the advance interim assessment, based on the funding necessary to support the pool's operating expenses for the coming fiscal year.

With each new fiscal year, the amount collected as advance interim assessment will be adjusted to match the actual assessment for fiscal year. For example, if the advance interim assessment for the 2009 fiscal year were set at 50 cents per covered life, but the portion of the actual operating loss funded by the industry assessment was 40 cents per covered life, the company would receive a credit of 10 cents against the advance interim assessment for the next fiscal year.

The advance interim assessment would also be adjusted for changes in the number of Covered Lives between projected and the actual in 2008.

29) What must I complete and return to the State for the Assessment?

Both the 2007 Health Benefit Reporting Form and the 2007 Covered Lives Worksheet must be completed and returned.

30) Must I complete the Assessment if I have no Covered Lives to report?

Yes, this Assessment needs to be completed and returned even if there are no Covered Lives to report.

31) Who do I contact with questions about the Assessment?

A special email address has been set up so that AccessTN can promptly address your questions. Please write us at Access.TN@state.tn.us. We will make every effort to respond to your email within one business day. You may also write us at AccessTN, 312 Rosa L. Parks Avenue, Suite 2600, Nashville, Tennessee 37243-1102.

32) When will I get a bill?

A Provisional Assessment will be sent on September 15, 2008 for company review. The offical Notice of Assessment will be sent October 31, 2008.

33) When do I pay?

Payment is due by December 31, 2008.

34) How do I pay?

Specific payment instructions will be included in the Notice of Assessment to be sent October 31, 2008.

35) What is the best way to learn more about the Cover Tennessee programs?

Information about each of the programs is also available at the Cover Tennessee website, www.CoverTennessee.gov, including information on AccessTN.

Supplemental FAQs about the AccessTN Company Assessment,

as of July 24, 2008.

36) Does Long Term Care count as Health Coverage?

No. Long term care is exempt from reporting on all sections of the the 2007 Health Benefit Plan Reporting Form and Worksheets, including Section 1.

37) If there is more than one reinsurer, who is primary for purposes of the assessment?

Sometimes a Tennessee licensed insurer will contract with a self-employed group or insurer for excess loss coverage or reinsurance and may in turn cede all or part of that financial risk, and sometimes certain administrative services, to another reinsurer. The receiving reinsurer may or may not be licensed to do business in Tennessee. The insurer or reinsurer contracted with the benefit group and licensed to do business in Tennessee is the primary insurer for purposes of the AccessTN assessment. This is true even if the receiving reinsurer contracts for the majority of the financial risk.

The receiving or accredited reinsurer would indicate in the worksheet for the 2007 Health Benefit Plan Reporting Form, at Section 5, the company name and covered lives of the primary reinsurer for each group. The primary insurer or reinsurer would report those lives in Box A and would potentially be financially responsible for the covered lives.

38) Why do insurers who do NOT write, provide, or administer Health Coverage need to report?

This first year, all insurers and benefit administrators need to report to tell AccessTN whether your company offers Health Cover or not. Otherwise, your company may potentially be subject to a default assessment. If your company reports that it does NOT offer Health Coverage in Tennessee, we can update our database for the purposes of future data calls. Future reporting will be subject to AccessTN procedures at that time.

All insurers and administrators of products other than Health Coverage need to provide a brief description of their product lines so that AccessTN may document that it is not Health Coverage. The reporting company may use a letter or the 2007 Health Benefits Plan Reporting Form to do so.